Plan Kenya
Kilifi Development Area
Child Survival XX
KIDCARE Project
KENYA

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FIRST ANNUAL REPORT

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IMPLEMENTING AGENCY

Plan Kenya Country Office
in partnership with

Ministry of Health, Aga Kan Health Services-Community Health Department, Amkeni, Kenya Medical Research Institute-Welcome Trust and Population Services International

LOCATION

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Name and position of individuals involved in writing and editing this report

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ACRONYMS

AKHS:	Aga Khan Health Services
ANC:	Ante Natal Care
ARI:	Acute Respiratory Infection
CBF:	Community Based Facilitators
CHDK:	Clean Home Delivery Kit
CHW:	Community Health Worker
CTC:	Child-To-Child
CWC:	Child Welfare Card
DA:	District Area
DCM:	Diarrhea Case Management
DHC:	Dispensary health Committee
DHMT:	District Health Management Team
DIP:	Detailed Implementation Plan
DMoH:	District Medical Officer of Health
DO:	District Officer
FMS:	Financial Management Systems
HAD:	Health Action days
HIS:	Health Information Systems
HIV:	Human Immunodeficiency Virus
ICT:	Internet and Communications Technology
IMCI:	Integrated Management of Childhood Illness
IMR:	Infant Mortality Rate
ITNs:	Insecticide Treated Nets
KEMRI:	Kenya Medical Research Institute
KEMSA:	Kenya Medical Supplies Agency
KID-CARE:	Kilifi District Coastal Area replication and Evolution
KPC:	Knowledge Practice and Coverage
LLTN:	Long lasting Treated Net
LQAS:	Lots Quality Assurance Sampling
MNC:	Maternal and Newborn Care (Safe motherhood)
MoH:	Ministry of Health
MOST:	Mobile Ongoing Sustainable Training
ORT:	Oral Rehydration Therapy
OVC:	Orphans & Vulnerable Children
PC:	Project Coordinator
PHC:	Primary Health Care
PMTCT:	Prevention of Mother To Child Transmission
PSI:	Population Services International
SA:	Supervision Area
TOF:	Trainer of Facilitators
TOT:	Trainer of Trainers
TT:	Tetanus Toxoid
UCI:	Universal Child Immunization
UNICEF:	United Nation Children’s Fund
VCT:	Voluntary Counselling and Testing
VHC:	Village Health Committee
WRA:	Women of Reproductive Age
WHO:	World Health Organization

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1.0 PLAN KENYA CHILD SURVIVAL PROJECT AT A GLANCE

Project duration	30 September 2004 – September 29, 2009
Project area	357 Villages in the 4 Divisions of Bahari, Vitengeni, Chonyi and Ganze of Kilifi District
Total population in the project Area:	257,522
Target beneficiaries	119,735
Health Facilities in project area	1 District hospital, 12 MOH Dispensaries, 1 Mission Dispensary, 4 Private Clinics
Social and economic profile of population in the project area	The inhabitants of the project comprise the Mijikenda ethnic group the majority of who are Giriama. The target group lives below the subsistence level working mostly as peasant farmers. As Kilifi Township also lies within the project area, a small cosmopolitan population is also represented.
Overall Goal	The goal of the program is to assist the MOH reduce in a sustainable way the morbidity and mortality of children and women of reproductive age in Kilifi.
Project interventions	- Diarrhea Case Management (DCM) - Pneumonia Case Management (PCM) - Malaria Case Management (MCM) - Prevention of Malnutrition - Increased immunization Coverage - Control of HIV/AIDS
Strategies	- Use of the care group approach to community mobilization - Strengthened community partnership and cost recovery - Promotion of project's objectives through innovative BCC/IEC strategies and Outreach (Quick wins) - Improved supervision and follow-up training to MOH health workers and volunteers - Integration of CS activities with Plan's core program - Collaboration with other local partners and NGOs. - Set-up of a Nurse Pool at the Kilifi District Hospital
Program objectives	**1. Behavioral:** Women of reproductive age and mothers of children under-five years will be practicing healthy behaviors and seeking medical care from trained health service providers; **2. Increased access to services:** Communities and families will have increased access to health education and quality care and essential medicines and supplies including ITNs and Water Chlorination Kits; **3. Quality of care:** MOH personnel, community health workers and other service providers including shopkeepers will be practicing appropriate integrated management of sick children particularly malaria case management. Practitioners and volunteers will also deliver quality counseling for care of sick children. **4. Institutional strengthening:** Dispensary Health Committees; local CBOs and district MOH facilities will be developed and strengthened to support and implement activities that enhance child survival.

2.0 MAIN ACCOMPLISHMENTS OF YEAR ONE

The KIDCARE project has taken off to a good start. The preparatory activities for the project startup began immediately Plan Kenya received information about the successful application. Plan initially contacted the local USAID Mission to share ideas about how to proceed and has kept close contact since. The project partners were involved through the planning and implementation of the baseline surveys and the hiring of the Project Coordinator. The project undertook an array of baseline studies that included a full census of all children under the age of 2 in the project area. This was a massive exercise that was made possible by the active participation of the local government in Kilifi represented by area chiefs. The census information updated the project statistics about the number of beneficiaries. A KPC survey using the 30-cluster sampling methodology was done for the project area and this was later followed by the application of the LQAS sampling methodology using the same tool for 11 Supervision Areas that were later identified. More than corroborate the 30-cluster information, the LQAS information gave statistics for individual supervision areas that would help with project monitoring. The project also performed an integrated Health Facility Assessment of all MOH health facilities and the Mission Dispensary. This study also explored the relationships between the Health facility and its community management committee (DHC) and specifically the capacity of the DHC. Qualitative studies were also done with key informants including mothers and key project partners. Finally the project also conducted a stakeholder workshop, closely following the DIP workshop, to define the local system and indicators for sustainability. This was facilitated by CSTS and was in response to Plan Kenya's successful response to and RFA put up by CSTS. The team identified and measured 66 indicators within the 3 dimensions of the CSSA framework. All these studies contributed to the program design and the writing of the DIP. Plan Kenya decided to write the DIP with its partners without hiring an external consultant. This provided opportunity for a lot of learning within Plan and its partners and increased the ownership of the DIP document by the partners. The Mini-University DIP Review presented a further opportunity to revise the DIP. The Kilifi MOH, who is the chief local partner of the project, was facilitated by the project to attend the DIP Review as well. Some of the major program tasks that have been done within the first year have had to do with community mobilization and organization. This has included strengthening of existing DHCs and VHCs and re-energizing their commitment to their mandate, their connectedness to the community and different community groups, and to their support to the CHWs who draw from the care groups. Three of the 11 SAs have completed care group formation. AKHS was able to complete a training needs assessment for DHC and VHC and repackage a training module that has already been applied to 2 of the 11 DHCs and 6 VHCs. The project frontline staff and the MOH have also been involved in conducting outreach activities (HADs) in hard to reach areas. The project recently concluded the 2nd LQAS survey in August and it reveals interesting results. Vitamin A supplementation for children 6-59 months showed a marked increase from 61% baseline (LQAS-1) to 72.8% (LQAS-2). While HADs have played a role in this, it could also be attributed to a major Vitamin A campaign held in July 05. There is some increase of correct use of ORS by caretakers for children with diarrhoea from 31% baseline (LQAS-1) to 33.2% (LQAS-2). There is also a steady increase of fully immunized children from 62% baseline to 65.6% (LQAS-2) and Mothers with TT2 during their last pregnancy from 24% (KPC) to 43% (LQAS-2). There is a steady increase of children who slept under ITN from 21% baseline to 27.6% (LQAS-2). In the area of case management the project conducted an IMCI Case Management Workshop that trained 15 health workers from the project area. The workshop also provided the opportunity to train the District MOH team as IMCI facilitators and this has built the capacity of the MOH in the case management supervisory function. At the community level, 100 CHWs were trained in the 1st module of C-IMCI training that focused on peer counseling of the nine key family health behaviors that have been sanctioned as priority behaviors by the Kenya National IMCI Working Group. Eighteen Public Health Officers and Technicians (MOH staff) were trained as TOTs to conduct this training and to provide supportive supervision to the CHWs. The community case management module is the 2nd part of the C-IMCI curriculum and will be given to the CHWs who show aptitude during their practicum. The Project has already trained 46 shopkeepers on dispensing of anti-malarials and 33 community

volunteers as peer educators for Puppetry as a means of communication for behavior change. Child-to-Child Health Clubs have already been formed in 4 Primary Schools.
One the national front, the project has kept very close to the MOH HQ especially the Division of Child Health, which was also instrumental in the DIP writing process. The four PVOs in Kenya who have child survival projects, World Vision in Teso, Catholic Relief Services in Mbeere, Africa Medical Research Foundation in Busia and Plan in Kilifi met in Machakos for the very first time to share learning and experiences and formalized to have annual meetings in the future.

The following matrix demonstrates project accomplishments during the first year against the objectives and key activities as identified in the DIP.

Goal: to assist the MOH reduce in a sustainable way the morbidity and mortality of children and women of reproductive age in Kilifi.

Project Objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
1. Objective on Behavior: Women of reproductive age, pregnant women and caregivers of children under 5 practice healthy behaviors and seek medical care from a trained provider when it is needed	**Control of Diarrheal Diseases** ▪ Training CHWs, health facility staff, community groups on management of Diarrheal diseases	▪ 100 CHWs received training of Diarrhea Prevention and 15 HWs received IMCI Training	Correct Use of ORS by caretakers has improved from 31% to 33.2% (LQAS-2)
	▪ Supervision and quality assurance monitoring of volunteer and health worker skills for management of diarrhea	▪ 18 Public Health Officers and Technicians as well members of the MOST team received training in Supervision.	
	▪ Behavior change communication using individual counseling on diarrhea management and prevention	▪ CHW and Community Puppetry Peer Educators have been trained to counsel mothers about management of Diarrhea.	

Project Objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
	Malaria and Pneumonia Control ▪ Train health facility staff and CHWs on malaria and pneumonia case management; ▪ Supervision and quality assurance monitoring of volunteer and health worker skills for pneumonia case management ▪ Behavior change communication about signs of pneumonia/Malaria ▪ Make ITNs more accessible	▪ 100 CHWs and all HF staffs were trained on IMCI. ▪ 36 Shopkeepers were trained on correct dispensing of malaria ▪ 33 peer educators on puppetry and pupils from 4 CTC clubs engaged caretakers in recognition of danger signs foe Pneumonia and Malaria in children. ▪ DHCs distributed subsidized Bednets delivered through PSI	ITN coverage for children the night before the survey has risen from 21% to 27.6% (LQAS-2)
	Immunization, Control of HIV/AIDS and Prevention of Malnutrition ▪ Train care group members on HIS, growth monitoring and peer counseling ▪ Behavior change communication about the benefits of completed immunization	▪ 318 care groups have been formed in 3 SAs and 44 HADs have been conducted in the Project Area ▪ The quality of counseling at HF is gradually improving now that all Health Workers in the dispensaries have been trained in IMCI. ▪ Behavior change communication through CHWs, Puppetry educators and CTC school pupils	Full Immunization coverage has risen from 62% to 65.6%, Vitamin A supplementation coverage from 61% to 72.8% and TT2 from 24% to 42% (LQAS-2)

Project Objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
2. Objective on increased access to Services and Supplies: Communities have increased sustainable access to health education, quality care and essential medicines and supplies.	▪ Establish DHC/VHC cost recovery scheme for Drugs and supplies ▪ Train DHC/VHC in HIS and FMS ▪ Facilitate links between VHC, DHC, Care groups ▪ Facilitate HADs	▪ Dispensary Services in Kenya are free of cost and the cost recovery is officially not welcome within the dispensary. However DHCs/VHCs are allowed to manage a cost recovery system without the dispensary ▪ PSI provides highly subsidized nets to DHCs through the MOH which are then made accessible to the communities ▪ The MOH with the assistance of the project is conducting regular Health Action Days to hard to reach areas.	
3. Objective on Quality of Care: MOH personnel and community volunteers (CHWs, TOFs) practice appropriate case management of diarrhea, malaria and pneumonia and provide quality counseling on child illness.	**Control of Diarrhoeal Disease** ▪ Train Health Workers on DCM, improved supervision ▪ Implementation of clinical IMCI ▪ Improved supervision and quality assurance monitoring ▪ Training of CHWs ▪ Joint supervision of CHWs, use of case management checklists to ensure and improve performance ▪ Establishment of community medicine chests to ensure ORS availability	▪ Frequent periodic/ planned supportive supervision is being done by the MOST Team ▪ All facilities are implementing clinical IMCI; ▪ Joint supportive supervision and quarterly review meetings at health post level ensure the quality of health services;	
	Malaria and Pneumonia Case Management ▪ Training for Health Workers, improved supervision ▪ Establishment and support of CHWs to improve referral of children with pneumonia ▪ Implementation of clinical IMCI ▪ Improved supervision and quality assurance monitoring ▪ Training of CHWs ▪ Joint supervision of CHWs, use of checklists to ensure and improve performance	▪ 100 CHWs have been trained on the 1st module of C-IMCI while 15 HWs were trained on the 11-day IMCI course; ▪ All facilities are implementing clinical IMCI; ▪ Joint supportive supervision and quarterly review meetings at health post level ensure the quality of health services;	

Project Objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
	Immunization, Control of HIV/AIDS and Prevention of Malnutrition ▪ Training of Care groups an HIS so that no child is left out; improved supervision ▪ Linking care groups to the dispensary through TOFs, VHC and DHC for effective support and supervision	▪ Care groups have been formed in 3 SAs and will be completed in the other 8 SAs by December ▪ There was dissemination of key CS message to Care group members through CHWs, Peer educators on Puppetry ▪ DHCs and VHCs were trained by AKHS on governance	
4. Institutional objectives: Local NGOs, MOH and community-based institutions have developed and strengthened capacity to support child survival activities on a sustainable basis.	▪ CHWs mobilization of care groups ▪ MOH and project staff mobilization of community committees ▪ Training of DHC/VHC on supportive supervision ▪ Joint supervision with MOH staff	▪ Care groups are linked to the VHCs through CHWs and VHCs are linked to the Dispensaries through DHCs ▪ DHCs are registered, have a bank account and a constitution that governs operations. ▪ All facilities are implementing cost recovery. ▪ Joint supervision with MoH staff has been regular.	

3.0 CONTRIBUTING FACTORS FOR SUCCESS:

Staff and team:

- Competent staff
- High morale and good team work

Backstopping and management support

- Adequate technical backstopping from Kenya Country Office (KCO) and International Headquarters (IH)
- Adequate management support from KCO, DA

Partnership and networking

- Good partnership with local NGOs and local dispensaries and MOH
- Good networking and coordination with all stakeholders from district to national levels

Community mobilization

- Mobilization of specific interest groups linked with the program intervention e.g. care groups and child clubs;
- Mobilization of community health volunteers in health activities
- Mobilization of local health committees

4.0 HINDRANCE FACTORS:

CONSTRAINTS	ALLEVATING STRATEGIES
MOH staff shortage	The recent civil servants strike had a heavy toll in Kilifi where a number of nurses who instigated the strike in the hospital wee relieved of their duties by the government. This made an already bad situation worse and severely compromises the running of the nurse pool which was intended to marshal public nurses on leave or off duty to spend time working in the project are dispensaries in exchange for a small stipend that the MOH pays to staff working overtime. The project is focusing on community-based interventions and working more with local health facility committees. The project has now embraced the idea of broadening the volunteer base as much as possible through the care group structure to make sure that there is a limited task for each volunteer to prevent attrition and also provide for supportive supervision by a multi-tiered structure of CHWs, TOFs, and Public Heath Officers and Technicians The project is also providing training and orientation for newly transferred staff on all intervention areas.
Disrupted Partner Presence/Mode of Operation	PSI has attained its social marketing goals for Kilifi and is slowly pulling out of the district. This also makes them committed to work is a specific way. For instance they would only provide ITN stock through the MOH and not through Plan. Plan recognized MOH as a collaborating partner and not as a sub grantee and is therefore still working out how it could facilitate MOH to procure ITN stock from PSI for the project area Initially the plan the project had was that AKHS would train DHCs and VHCs directly in HIS and FMS. After some lengthy discussion and also because of cost implications it was decided that AKHS will train master trainers from among the MOH, other partners and possibly project staff who will in turn train the DHCs and VHCs
Additional Frontline staff for the Project	The DIP planned 9 extra frontline staff for the project (to make a total of 13) to be paid for by match funds. However Plan was not able to raise enough funding and a decision was made to hire four extra staff (to make a total of 8) instead. While this represents a shortfall from what was planned it is still better that how the project started out and the good news is that the capacity of these extra staff is higher than was initially envisaged. Thus they are able to take up an extra load, which will include being responsible over care groups represented in more than a single Supervision Area.
Use of Co-artem by CHWs	The MOH has not yet given a go-ahead to community practitioners to use Co-artem but the project is still engaged in discussions with MOH to allow a pilot
Drought and Scarcity of Food	Parts of the project area are currently hard hit by drought and scarcity of food. Stakeholders are working with the communities and government to provide relief. Specifically the project is mobilizing the care group structure to identify children who need hospital care because of malnutrition

5.0 REQUIRED TECHNICAL ASSISTANCE

- Technical assistance will be required for PD/HEARTH startup in Ganze. Terms of Reference for the work had been completed and a consultant has been identified to do this work. Another area that will need technical assistance is the BEHAVE framework workshop for project stakeholders and the Mid term and Final Evaluations.

6.0 OVERALL MANAGEMENT OF THE PROJECT

In line with the overall management strategy outlined in the DIP, the project work has been divided into eleven supervision areas. The project staff worked very closely in collaboration with the local health facility staff and volunteers (DHCs, VHCs, CHWs), care groups and partners. Altogether, there are 10 field staff that include: 2 Program Officers (POs), and 8 Community Based Facilitators (CBF). CBFs operate their field activities from their own assigned supervisory field area offices. The program officers are responsible for undertaking training, health information system management and BCC/IEC coordination. The Project Accountant and Administrative Assistant take care of the financial and administrative function. The PC is responsible for overall coordination and management of the project activities. Plan Kenya's Country Office through the DA manager technically and administratively supports the project. It receives regular support from National Health Adviser. In addition, the project also gets technical, management and administrative backstopping from Plan's Washington Office that is also the project's link between Plan and USAID.
The management structure of the project has been designed in a way that facilitates a participatory approach to decision making. While project staff and the different Plan and partner's offices perform distinct roles and responsibilities, day to day planning, decision-making and implementation is done at the field level. Management and staff review work during monthly staff meetings.

A field team is assigned to each of the 11 supervision areas. The Project Coordinator is responsible for overall management, implementation and quality of the project as well as for technical backstopping to the field team. The Project Coordinator administratively reports to the District Area Manager but technically reports to the National Health Adviser.

6.1 Financial Management

Monthly financial reports, following a pre-agreed format, are sent by Project Coordinator (PC) to country office and then to IH. Plan Kenya's already established financial system (General ledger) tracks project expenditure. Expenditure is broken down according to specific codes like training, equipment, supplies and supervision. Project expenditure reports are reviewed for USAID compliance and then submitted to USAID. The project annual budget for the coming fiscal year, based on its DIP approved workplan, is consolidated with the Plan Kenya Budget for the following year and is sent to the Regional Office (RO) of Plan for approval. Annual budget approval from IH and RO is received each year before stating the Fiscal Year. Plan's corporate general ledger system assigns a project specific number to enable accurate tracking of project expenditures.

6.2 Human Resources

Community level Volunteers (4-8 hours per week): Care group members are responsible for working with mothers in the project intervention areas. They diagnose sick children and initiate rapid referral or offer treatment if they have also been trained as a CHW. They are responsible for convening Mothers' Group meetings on a monthly basis.

The number of care groups in the project area is still rising. In the 3 SAs of Jaribuni, Ganze and Muryachakwe it is 318.
MoH staff: A Nurse (Health Worker) is charged with running the dispensary and is supported by a Public Health Technician/Officer. The nurse is responsible for regular MoH health interventions including IMCI services. The Public Health Technician is responsible for outreach activities and supportive supervision to CHWs.

AKHS/AMKENI (Partners): These partners are responsible for providing training in governance/HIS/Logistic Management and BCC/IEC activities respectively.

Core CS Staff (100% effort): There is a total of 14 staff including administration/finance and support. The Community Based Facilitators work directly with health facility staff and community volunteers to support and monitor project activities. All the project staff speaks Kiswahili, which is well understood at community level. The major task of Project staff is to build community and MOH capacity to demand for and deliver quality service. Project staffs do not directly deliver services.

Plan Staff: The Senior Health Program Manager (IH) and the Health Associate (IH) dedicate 10% and 25% of their time respectively as project backstops. The Plan Nepal National Health Coordinator dedicates 15% of his field time whereas District Program Coordinator dedicates 25% of his time for management support towards the project.

6.3 Communication Systems and Team Development

The technical backstopping team at Plan's Washington DC Office shares relevant technical information to the field office as they receive it, particularly from CSTS and CORE. The CS Project Coordinator is in the CSTS list-serve and receives periodic Bookmarks via the Internet, which the project has access to. All project staff are fluent in English. The project office has reliable email, Internet, telephone, and fax facilities.

6.4 Relationship with Local Partners

The major partners of Plan CS Project are District Ministry of Health, Local Health Facilities and its management committees, AKHS, AMKENI, KEMRI-Wellcome Trust and PSI. In addition, other collaborating partners include Community Based Organizations including School and Water committees, Local Government and Local Politicians. Plan CS Project coordinates actively with these local partners while designing and implementing programs in the project area and always in close collaboration with the community and MOH. Coordination meetings are held with all the district level partners on a quarterly basis. The project had included the staff of partner organizations in relevant training to build their capacity in their respective interventions.

6.5 PVO Coordination/Collaboration in Country

The project is a member of the Kenya National Alliance Against Malaria (KeNAAM), which is funded by CORE. This has been helpful in enhancing field level capacity through sharing best practices. Plan is a member of the National IMCI Working Group and has provided opportunity to pilot strategies and share community program experience through the child survival project. Plan Kenya is also a member of the Cooperative Agency Meeting that brings together the Local Mission, Cooperative Agencies, PVOs and National NGOs to learn from one another and plan about how to strategically work together in the country.

6.6 Other Relevant Management Systems

The project follows the Plan Kenya system for procurement. All requests for equipment and supplies are made to the General Services Office within the District Area Office. This office examines prices and quality from several suppliers, collecting at least three official bids on items costing more than $ 250 as per guidelines. General Services makes a purchase order once the vendor is chosen and the item is shipped directly to the CS Project Office. General Services is also responsible for purchasing and delivering items not available in local markets. The Administration and Finance Officer inspects the goods upon receipt to ensure their quality. Items valued at more than $250 are recorded in the inventory at the General Services Office. A copy of this inventory is also maintained at the CS project office for dual tracking. Each item is given a number before being sent to the regular users. Items valued at less then $ 250 are recorded in the same way but the inventory is maintained only at the CS Project Office. In case an item requires technical inspection, General Services invites appropriate persons to be a part of the assessment team.

8.0 RELATIONSHIPS WITH LOCAL MISSION

Plan Kenya has a warm relationship with the Local Mission in Nairobi. Local Mission representatives participated in the DIP Preparation activities. Plan Kenya and the Local Mission maintain regular communication. During each visit from IH, Plan has always organized debriefing meetings at the Mission.

Plan Kenya actively participated during the first Child Survival PVO network in Machakos called between World Vision, Africa Medical Research Institute (AMREF), Catholic Relief Services and Plan to discuss and share experiences about Child Survival. This meeting had the full support of the Local Mission

9.0 RESPONSE TO DIP REVIEW COMMENTS

The project scaled down HIV/AIDS activities as highlighted during the DIP Review. It has also hired 4 out of 9 extra Community Based Facilitators. This makes a total of 8 for the project. While this represents a shortfall from what was planned, the caliber of these staff is higher than was initially envisaged and the project plans to share the workload among these staff.

10.0 CIVIL SOCIETY DEVELOPMENT AND EQUITY

Plan is a Child Centered Community development (CCCD) organization that seeks to build the community understanding that they are right holders who should boldly access services from duty bearers (government, civil society). Through child clubs supported by Plan's core program called "Msingi Bora" or "Good Foundation", pupils dialogue about their rights and responsibilities. Formulation of community development plans for all communities that Plan works with everywhere integrate the opinions of the children and those who are otherwise marginalized. Examples include where a new water point or school building should be cited, for example.

The project is sensitive to this as it works in the project area and is insuring that all groups have a voice in the dispensary and village health committees that are being formed.

The adoption of universal and free health care by the government makes health care accessible to those who are near the health facilities. The project has committed to hold regular HADs to hard to reach areas to get to those who would not otherwise access health care.